0 – 5 YEARS OLD

MIAMI-DADE COUNTY
COMMUNITY ACTION AND HUMAN SERVICES DEPARTMENT
HEAD START/EARLY HEAD START DIVISION
REGISTRATION REQUIREMENTS

(Parent/Legal Guardian Copy)

Documentation for proof of birth, proof of income, Parent/Guardian picture ID and proof of Miami-Dade County residency is needed at the time of the application intake. This information is used to determine program eligibility. If "yes" was checked on the family circumstances checklist on page 2 of the application you must provide documentation for those items. Staff is available to assist with the completion of the application.

Proof of Age: • **EHS** - Pregnant women can be any age. Children: Birth to age 3 years after September 1, 2016. • **HS** - Children **must** be 3 or 4 years of age on or before September 1, 2016, or no more than five (5) years old after September 1, 2016.	• **Birth Certificate** • **Passport** • **Notarized Affidavit of Age Form** • **Doctor's statement (pregnant women)**
Proof of parent's/legal guardian gross income for the <u>past 12 months or the last calendar year (2015)</u>.	• **Signed Income Tax 1040 with eligible child name listed** • **W-2 form(s)** • **pay stubs** • **Unemployment Compensation** • **Written statement from employers on letterhead** • **Social Security Supplemental Income (SSI) print-out** • **TANF print-out** • **Child Support Agency** • **Income Statement Form**
Proof of Parent's Identification	• **Driver's license/Passport** • **State issued picture I.D.** • **Employer issued I.D./Military I.D.** • **Homeless Shelter I.D.**
Proof of Dade County Residency	• **Driver's license** • **State issued picture I.D. with address listed** • **Utility Bills (lights, phone, cable, etc.)** • **Lease/Rental and/or Mortgage Agreement** • **TANF/SSI/Unemployment Letter**
Proof of Disability	• **Individualized Educational Plan (IEP)** • **Individualized Family Support Plan IFSP**
Proof of Suspected Disability	• **Doctor/Therapist evaluations and statements outlining concerns**
Proof of Homelessness Verification	• **Statement from homeless facility or social worker** • **Statement from applicant**
Proof of Substance Abuse	• **Statement from Treatment Program Staff**
Proof of Domestic Violence	• **Statement from Domestic Violence Agency/Staff** • **Court Documentation (within the last year)**
Proof of Student Status	• **Current Transcript/Class Schedule**
Proof of Education Eight Grade and Below	• **Statement from Applicant/Official School Transcript**
Proof of Parental Disability	• **SSI Recipient Letter/Doctor's Statement**
Proof of Pregnancy	• **Medical Documentation (current)**
Proof of Public Housing Residency	• **MDPHA Rental/Lease Agreement**
Proof of Foster Care-Legal Custody	• **Documentation from Foster Care Agency/Court Award**
Proof of Legal Guardianship/Custody	• **Documentation from the Court System/Court Award**

Parents must verify that the information provided on the application and supporting documentation is true and correct and that all parent(s)/legal guardian(s) income are reported. Deliberate misrepresentation of any information submitted may result in the child being terminated from the program. An incomplete application and missing documentation will delay the enrollment process.

Miami-Dade County
Community Action and Human Services Department
Head Start/Early Head Start Division
Family Information
APPLICATION

Primary Adult Name: _____ **Birthdate**: _____

Eligible Child Name: _____ **Birthdate**: _____

General Information:

Living Address:	**City**	**State**	**Zip Code**	**County: MIAMI-DADE**
Mailing Address (if different):	**City**	**State**	**Zip Code**	

Phone Number(s)	Home, Work, Cellular, E-mail	Primary	Notes

Number in Household _____ (Living with Child) **Number in Family** _____ (Supported by the income of parent or guardian) **Total Number(s) of Children** _____ **Age(s)** 0-3 _____ **Age(s)** 4-5 _____

Parental Status:
☐ Biological/Adopted/Stepparent ☐ Foster*
☐ Legal Guardian* ☐ Grandparent*
☐ Niece/Nephew*
☐ Other, specify*_____

☐ **One parent** ☐ **Two parents**
*** Legal court documentation is required to enroll child.**

Primary Language of family at home:
☐ English ☐ Spanish ☐ Creole
☐ African ☐ European & Slavic ☐ Pacific Island
☐ East Asian ☐ Middle Eastern & South Asian
☐ Native North American /Alaskan
☐ North Central American, South American
☐ Other: _____

Center Applying for:

Family Income:

TANF: ☐Yes ☐No ☐Formerly **SSI:** ☐Yes ☐No **Food Stamps/SNAP:** ☐Yes ☐No **WIC:** ☐Yes ☐No **WIC ID#** _____

STAFF USE ONLY

Income Source		Frequency
Earned Income (1040, W-2, pay stubs, employer letter)		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month
Public Assistance, Welfare (i.e. TANF, AFDC)		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month
Social Security Pension / Retirement		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month
Supplemental Security Insurance (SSI)		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month
Foster Care Reimbursement		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month
Unemployment Compensation		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month
Child Support/Alimony		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month
Other, explain:		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month

Income Notes:

Emergency Contacts: (please complete carefully)

Name: _____ **Relationship:** _____

Address: _____ City: _____ Zip: _____ Phone#: _____ Phone#: _____

Name: _____ **Relationship:** _____

Address: City: Zip: Phone#: Phone#:

Medical/Dental Providers: (please complete carefully)

(Medical Provider): Does the child have an on-going source of continuous, accessible medical care (medical home)? ☐ **Yes** ☐ **No**

Doctor Name: Address: Phone #:

☐ **If No Doctor*** ***STAFF USE ONLY**
(Staff Referred TO Medical Provider): Date: Staff Person Referred by:

(Dental Provider): Does the child have an on-going source of continuous, accessible dental care (dental home)? ☐ **Yes** ☐ **No**

Dentist Name: Address: Phone #:

☐ **If No Dentist*** ***STAFF USE ONLY**
(Staff Referred TO Dental Provider): Date: Staff Person Referred by:

Miami-Dade County
Community Action and Human Services Department
Head Start/Early Head Start Division
ELIGIBLE CHILD INFORMATION

Eligible Child (New Enrollee):

Last	First	Middle	Nickname	Suffix

Birthdate:	Gender: ☐ M ☐ F	Proof of age verified: ☐ Yes ☐ No	Source of age verification: ☐ Birth Certificate ☐Passport ☐Doctor Statement (Pregnant Woman) ☐ Notarized Affidavit of Age ☐ Other(Specify):

Race:

☐ Asian
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Native Hawaiian or other Pacific Islander
☐ White
☐ Bi-racial/Multi-racial

Ethnicity:

☐ Hispanic or Latino Origin

☐ Non-Hispanic or Latino Origin

Nationality:_____

English Proficiency:
☐ None ☐ Poor ☐ Moderate ☐ Proficient

Other Language Spoken:
☐ None ☐ Poor ☐ Moderate ☐ Proficient

Primary Adult Relationship to Child:

☐ Biological ☐ Grandchild * ☐ Foster* ☐ Adopted*
☐ Step Child ☐ Niece/Nephew * ☐ Legal Guardian*
☐ Other* (specify)_____

Secondary Adult Relationship to Child:

☐ Biological ☐ Grandchild* ☐ Foster* ☐ Adopted*
☐ Step Child ☐ Niece/Nephew* ☐ Legal Guardian*
☐ Other *(Specify)_ _____

Is there a current Order of Protection or No Contact Order which concerns this child? ☐ Yes ☐ No

*** Legal court documentation is required to enroll child.**

Medicaid Eligibility:

☐ On Medicaid ☐ Potentially Eligible
☐ Not Eligible

Medicaid Number:_____

Health Care Provider Name:

_____

Insurance Number: _____

☐ Other/Private Health Coverage(list name of provider):

_____

☐ No Health Insurance Coverage

Referral completed to:

_____

Florida KidCare Application Completed Date:_____

Staff:_____ Date: _____

Special Needs/Disability:

Miami-Dade County Public School Diagnosed Disability Evaluation-Individualized Education Plan (IEP):	☐ No ☐ Yes	**If YES Date:**
Early Steps Program-Individualized Family Support Plan (IFSP):	☐ No ☐ Yes	**If YES Date:**
Professional Diagnosis (speech therapy, occupational, etc.):	☐ No ☐ Yes	**If YES Date:**

Assistive Devices Used: ☐No Assistive Devices ☐Glasses ☐Contact Lenses ☐Crutches ☐Walker ☐Cane ☐Wheelchair ☐Braces ☐Hearing Aides

Health Services:

Does your child receive medical treatment for : ☐ Anemia ☐Asthma ☐ Diabetes ☐ High Lead Level ☐Other, specify:
☐ No medical treatment

List all known allergies, dietary needs or other medical/dental areas of concerns: **Describe:**
☐ None known

Family Circumstances: (please complete carefully)

Family Demographics: Place check ☑ in appropriate box	**Yes**	**No**	**Parental Status:** Place check ☑ in appropriate box	**Yes**	**No**
Documented Substance abuse			One Parent		
Documented Domestic Violence			Two Parents		
Documented Parent education <8th grade			Foster Parent		
Documented Teen Parent <17 years old			Legal Guardian		
Homeless: Length of time homeless: / Agency Name:			**Family Services:** Place check ☑ in appropriate box	**Yes**	**No**
Documented Pregnant Women			Medicaid/ Florida KidCare		
Documented Public Housing Resident (MPHA)			Food Stamps/SNAP		
Documented Parental Disability			WIC		
Transition from Early Head Start to Head Start			Public Assistance/ Welfare TANF/AFDC		
Documented Working Parent / Student			Supplemental Security Income (SSI)		
Returning Sibling(s) in Head Start/Early Head Start			Referred from a Foster Program		
Documented –Referred for services by a child welfare agency			Referred from Florida Department of Children and Families or Court Ordered		

Miami-Dade County
Community Action and Human Services Department
Head Start/Early Head Start Division
FAMILY MEMBER INFORMATION

Primary Adult (Parent/Legal Guardian):

Last	First	Middle	Birthdate	Gender: ☐ Male ☐ Female

☐ **Lives with Family** ☐ **Custody** ☐ **Provides Financial Support** ☐ **Teen Parent**

Language Proficiency:

English
☐ None ☐ Poor ☐ Moderate ☐ Proficient

Other Language Spoken:_____
☐ None ☐ Poor ☐ Moderate ☐ Proficient

Race:
☐ Asian
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Native Hawaiian or other Pacific Islander
☐ White
☐ Bi-racial/Multi-racial

Education:
☐ An advanced degree or baccalaureate degree
☐ An associate degree, vocational school, or some college
☐ High school graduate or GED
☐ 9th – 12th grade
☐ less than 8th grade

Job Training/School:
☐ Is in job training or school
☐ Is **NOT** in job training or school

Ethnicity:
☐ Hispanic or Latino Origin
☐ Non-Hispanic or Latino Origin

Secondary Adult (Parent/Legal Guardian):

Last	First	Middle	Birthdate	Gender: ☐ Male ☐ Female

☐ **Lives with Family** ☐ **Custody** ☐ **Provides Financial Support** ☐ **Teen Parent**

Language Proficiency:

English
☐ None ☐ Poor ☐ Moderate ☐ Proficient

Other Language Spoken:_____
☐ None ☐ Poor ☐ Moderate ☐ Proficient

Race:
☐ Asian
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Native Hawaiian or other Pacific Islander
☐ White
☐ Bi-racial/Multi-racial

Education:
☐ An advanced degree or baccalaureate degree
☐ An associate degree, vocational school, or some college
☐ High school graduate or GED
☐ 9th – 12th grade
☐ less than 8th grade

Job Training/School:
☐ Is in job training or school
☐ Is **NOT** in job training or school

Ethnicity:
☐ Hispanic or Latino Origin
☐ Non-Hispanic or Latino Origin

EMPLOYMENT: (Parents/Legal Guardians)

Primary Adult:
☐ Is **EMPLOYED** Effective date:_____
☐ Is **UNEMPLOYED** (i.e. not working, retired, or disabled)
Effective date:_____
☐ Member of U.S. Military ☐ Military Veteran ☐ N/A

Secondary Adult:
☐ Is **EMPLOYED: E**ffective date:_____
☐ Is **UNEMPLOYED** (i.e. not working, retired, or disabled)
Effective date:_____
☐ Member of U.S. Military ☐ Military Veteran ☐ N/A

Other Family Members (Supported by the income of the parent or legal guardian):

Adult/Child	Last	First	Birthdate	Gender	Relationship to Child
☐Adult ☐Child				☐ Male ☐ Female	
☐Adult ☐Child				☐ Male ☐ Female	
☐Adult ☐Child				☐ Male ☐ Female	
☐Adult ☐Child				☐ Male ☐ Female	

Application/ Referral Source (required):
☐ Early Learning Coalition ☐ MCI ☐ Community Outreach ☐ Court Ordered Referral ☐ Department of Children & Families ☐ Disability Program
☐ Early Head Start ☐ Family/Friend ☐ Flea Market ☐ Former Parent ☐ Hospital/Health Clinic ☐ Healthy Start ☐Hotline ☐ Public Housing
☐ Public or Private Non-Profit Organization ☐ Public Schools ☐ Resource & Referral Agency ☐ Self-Referral ☐ South Florida Workforce ☐ WIC
☐Unemployment ☐Youth Fair ☐ Other (specify):_____

Verification (signature required): ***Please Read Before Signing***

I verify that the information provided in this application package, and the proof of income provided for enrollment eligibility, is accurate and truthful to the best of my knowledge. I am aware that providing false income/information could result in dismissal from the program.

Parent/Guardian Print Name: _____ **Date:** _____

Parent/Guardian Signature: **Date:**